Senate Bill 36

By: Senator Jones of the 10th

A BILL TO BE ENTITLED

AN ACT

To amend Title 9 of the Official Code of Georgia Annotated, relating to civil practice, so as to enact a new chapter relating to medical malpractice actions; to provide for applicability; to provide for definitions; to provide for qualifications of health care providers under the chapter; to provide for proof of financial responsibility and surcharges by health care providers; to provide for procedures for the establishment of financial responsibility; to provide for an annual surcharge on health care providers; to provide for the computation and collection of an annual surcharge; to provide for the creation of the patient´s compensation fund; to provide for the payment and processing of claims for the fund; to provide for the tolling of the applicable statute of limitations; to provide for the presentation of a claim for medical malpractice to a medical review panel prior to commencing an action; to provide for exceptions to the requirement to commence a medical review panel; to provide for the establishment of medical review panels; to provide for the composition, procedures, and operation of medical review panels; to provide for a report by a medical review panel; to provide for health care provider liability based on breach of contract; to provide for a duty to obtain informed consent; to provide for form of consent; to provide for exceptions to obtaining informed consent; to provide for a limitation on the period of liability with relation to malpractice coverage; to provide for limitations on damages for liability under this chapter; to provide for payments from the patient´s compensation fund; to provide for claims in excess of policy limits; to provide for advance payments; to provide that a patient´s claim is not assignable; to provide for the creation of the residual malpractice insurance authority; to provide for the duties and operation of the authority; to provide for a segregated fund for the authority; to provide for attorney´s fees from the patient´s compensation fund; to provide for related matters; to provide for related matters; to provide for a contingent effective date; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Title 9 of the Official Code of Georgia Annotated, relating to civil practice, is amended by adding after Chapter 9 a new Chapter 9A to read as follows:

"CHAPTER 9A

ARTICLE 1

9-9A-1.

This chapter shall not apply to an act of malpractice that occurred prior to July 1, 2005.

9-9A-2.

As used in this chapter, the term:

(1) 'Annual aggregate' means the limitation on a health care provider's liability as provided in Code Section 9-9A-10.

(2) 'Authority' refers to the residual malpractice insurance authority established under Code Section 9-9A-141.

(3) 'Commissioner' means the Commissioner of Insurance.

(4) 'Department' means the Insurance Department.

(5) 'Health care' means an act or treatment performed or furnished, or that should have been performed or furnished, by a health care provider for, to, or on behalf of a patient during the patient's medical care, treatment, or confinement.

(6) 'Health care provider' means any person licensed under Chapter 9, 11, 26, 30, 33, 34, 35, or 39 of Title 43 or any hospital, nursing home, home health agency, institution, or medical facility licensed or defined under Chapter 7 of Title 31. The term shall also include any corporation, professional corporation, partnership, limited liability company, limited liability partnership, authority, or other entity comprised of such health care providers.

(7) 'Hospital' means a facility that has a valid permit or provisional permit issued by the Department of Human Resources under Chapter 7 of Title 31.

(8) 'Insurer' means the authority or an insurance company or other entity authorized to issue medical malpractice liability insurance pursuant to Title 33.

(9) 'Long-term care facility' means a nursing home, personal care home, or intermediate care facility that is licensed or permitted under Title 31.

(10) 'Malpractice' means a tort or breach of contract based on health care or professional services that were provided, or that should have been provided, by a health care provider to a patient.

(11) 'Medical facility' means any institution or medical facility licensed as such under Chapter 7 of Title 31.

(12) 'Patient' means an individual who receives or should have received health care from a health care provider under a contract, express or implied, and includes a person having a claim of any kind, whether derivative or otherwise, as a result of alleged malpractice on the part of a health care provider. Derivative claims include the claim of a parent or parents, guardian, trustee, child, relative, attorney, or any other representative of the patient including claims for loss of services, loss of consortium, expenses, and other similar claims.

(13) 'Physician' means an individual with an unlimited license to practice medicine under Article 2 of Chapter 34 of Title 43.

(14) 'Qualified provider' means a health care provider that is qualified under this chapter by complying with the procedures set forth in Code Section 9-9A-3.

(15) 'Representative' means the spouse, parent, guardian, trustee, attorney, or other legal agent of the patient.

(16) 'Risk' means a health care provider that must apply for malpractice liability insurance coverage under Article 14 of this chapter.

(17) 'Risk manager' means an insurance company that is:

(A) Authorized to issue medical malpractice liability insurance pursuant to Title 33; and

(B) Appointed by the Commissioner to manage the authority.

ARTICLE 2

9-9A-3.

(a) A health care provider who fails to qualify under this chapter is not covered by this chapter and is subject to liability under the law without regard to this chapter. If a health care provider does not qualify, a patient´s remedy is not affected by this chapter.

(b) For a health care provider to be qualified under this chapter, the health care provider or the health care provider´s insurance carrier shall:

(1) Cause to be filed with the Commissioner proof of financial responsibility as established under Code Section 9-9A-10; and

(2) Pay the surcharge assessed on all health care providers pursuant to Article 4 of this chapter.

(c) The officers, agents, and employees of a health care provider, while acting in the course and scope of their employment, may be qualified under this chapter if the following conditions are met:

(1) The officers, agents, and employees are individually named or are members of a named class in the proof of financial responsibility filed by the health care provider under Article 3 of this chapter.

(2) The surcharge assessed pursuant to Article 4 of this chapter is paid.

(d) A claim against the state or a political subdivision of the state, or an employee of the state or a political subdivision of the state, based on an occurrence of malpractice is governed exclusively by this chapter if the governmental entity or employee is qualified under this chapter.

9-9A-4.

(a) Except as provided in subsection (b) of this Code section, the receipt of proof of financial responsibility and the surcharge constitutes compliance with subsection (b) of Code Section 9-9A-3:

(1) As of the date on which they are received; or

(2) As of the effective date of the policy

if this proof is filed with and the surcharge paid to the department not later than 90 days after the effective date of the insurance policy.

(b) If an insurer files proof of financial responsibility and makes payment of the surcharge to the department at least 91 days but not more than 180 days after the policy effective date, the health care provider is in compliance with subsection (b) of Code Section 9-9A-3 if the insurer demonstrates to the satisfaction of the Commissioner that the insurer:

(1) Received the premium and surcharge in a timely manner; and

(2) Erred in transmitting the surcharge in a timely manner.

(c) If the Commissioner accepts a filing as timely under subsection (b) of this Code section, the filing must, in addition to any penalties under Code Section 9-9A-22, be accompanied by a penalty amount as follows:

(1) Ten percent of the surcharge, if the proof of financial responsibility and surcharge are received by the Commissioner at least 91 days and not more than 120 days after the original effective date of the policy;

(2) Twenty percent of the surcharge, if the proof of financial responsibility and surcharge are received by the Commissioner at least 121 days and not more than 150 days after the original effective date of the policy; or

(3) Fifty percent of the surcharge, if the proof of financial responsibility and surcharge are received by the Commissioner at least 151 days and not more than 180 days after the original effective date of the policy.

9-9A-5.

Within five business days after the department receives the information required under subsection (b) of Code Section 9-9A-3 for the qualification of a health care provider, the Commissioner shall notify the health care provider of the following:

(1) Whether the provider is qualified; and

(2) If the provider is qualified, the date the provider becomes qualified.

9-9A-6.

The Commissioner shall promulgate rules to implement this chapter.

ARTICLE 3

9-9A-10.

Financial responsibility of a health care provider and the provider´s officers, agents, and employees while acting in the course and scope of their employment with the health care provider may be established:

(1) By the health care provider´s insurance carrier filing with the Commissioner proof that the health care provider is insured by a policy of malpractice liability insurance in the amount of at least $250,000.00 per occurrence and $750,000.00 in the annual aggregate, except for the following:

(A) If the health care provider is a hospital, as defined in Code Section 9-9A-2, the minimum annual aggregate insurance amount is as follows:

(i) For hospitals of not more than 100 beds, $5,000,000.00; or

(ii) For hospitals of more than 100 beds, $7,500,000.00;

(B) If the health care provider is a health maintenance organization as defined in Chapter 21 of Title 33, the minimum annual aggregate insurance amount is $1,750,000.00; or

(C) If the health care provider is a long-term care facility, the minimum annual aggregate insurance amount is as follows:

(i) For long-term care facilities with not more than 100 beds, $750,000.00;

(ii) For long-term care facilities with more than 100 beds, $1,250,000.00;

(2) By filing and maintaining with the Commissioner cash or a surety bond approved by the Commissioner in the amounts set forth in paragraph (1) of this Code section; or

(3) If the health care provider is a hospital, by submitting annually a verified financial statement that, in the discretion of the Commissioner, adequately demonstrates that the current and future financial responsibility of the health care provider is sufficient to satisfy all potential malpractice claims incurred by the provider or the provider´s officers, agents, and employees while acting in the course and scope of their employment up to a total of $250,000.00 per occurrence and annual aggregates as follows:

(A) For hospitals of not more than 100 beds, $5,000,000.00; or

(B) For hospitals of more than 100 beds, $7,500,000.00.

The Commissioner may require the deposit of security to assure continued financial responsibility.

9-9A-11.

Security provided under paragraph (2) of Code Section 9-9A-10 may be held in any manner mutually agreeable to the Commissioner and the health care provider. The agreement must provide that the principal may not be withdrawn before receiving the written permission of the Commissioner. However, any interest earned may be withdrawn at any time by the health care provider.

9-9A-12.

To establish financial responsibility under this article, each individual who is a member of a partnership or professional corporation must establish financial responsibility separate from the partnership or professional corporation as well as pay the surcharge required under Code Section 9-9A-21. However, this Code section does not require a health care provider to qualify under this article.

ARTICLE 4

9-9A-20.

To create a source of funding for the patient´s compensation fund, an annual surcharge shall be levied on all health care providers in Georgia.

9-9A-21.

(a) The actuarial program used or created by the department to determine the actuarial risk posed to the patient compensation fund under Article 5 of this chapter by a hospital must be:

(1) Developed to calculate actuarial risk posed by a hospital, taking into consideration risk management programs used by the hospital;

(2) An efficient and accurate means of calculating a hospital´s malpractice actuarial risk;

(3) Publicly identified by the department by July 1 of each year; and

(4) Made available to a hospital´s malpractice insurance carrier for purposes of calculating the hospital´s surcharge under subsection (g) of this Code section.

(b) Except as provided in subsections (f) and (g) of this Code section, beginning July 1, 2006, the amount of the annual surcharge shall be 100% of the cost to each health care provider for maintenance of financial responsibility. Except as provided in subsections (f) and (g) of this Code section, beginning July 1, 2008, the annual surcharge shall be set pursuant to rules adopted by the Commissioner.

(c) The amount of the surcharge shall be determined based upon actuarial principles and actuarial studies and must be adequate for the payment of claims and expenses from the patient´s compensation fund.

(d) The surcharge for qualified providers other than physicians and hospitals may not exceed the actuarial risk posed to the patient´s compensation fund under Article 5 of this chapter by qualified providers other than physicians and hospitals.

(e) There is imposed a minimum annual surcharge of $100.00.

(f) Notwithstanding subsections (b), (c), and (e) of this Code section, beginning July 1, 2006, the surcharge for a qualified provider who is a physician is calculated as follows:

(1) The Commissioner shall contract with an actuary that has experience in calculating the actuarial risks posed by physicians. Not later than July 1 of each year, the actuary shall calculate the median of the premiums paid for malpractice liability policies to the malpractice insurance carrier or carriers in the state that have underwritten the most malpractice insurance policies for all physicians practicing in the same specialty class in Georgia during the previous 12 month period. In calculating the median, the actuary shall consider the:

(A) Manual rates of the leading malpractice insurance carrier or carriers in the state; and

(B) Aggregate credits or debits to the manual rates given during the previous 12 month period.

(2) After making the calculation described in paragraph (1) of this subsection, the actuary shall establish a uniform surcharge for all licensed physicians practicing in the same specialty class. This surcharge must be based on a percentage of the median calculated in paragraph (1) of this subsection for all licensed physicians practicing in the same specialty class under rules adopted by the Commissioner. The surcharge must be sufficient to cover and may not exceed the actuarial risk posed to the patient compensation fund under Article 5 of this chapter by physicians practicing in the specialty class.

(g) Beginning July 1, 2006, the surcharge for a hospital that establishes financial responsibility under Code Section 9-9A-10 after June 30, 2006, shall be established by the department through the use of an actuarial program. At the time financial responsibility is established for the hospital, the hospital shall pay the surcharge amount established for the hospital under this Code section. The surcharge must be sufficient to cover and may not exceed the actuarial risk posed to the patient compensation fund under Article 5 of this chapter by the hospital.

(h) An actuarial program used or developed under subsection (a) of this Code section shall be treated as a public record and shall be subject to Article 4 of Chapter 18 of Title 50, relating to inspection of public records.

9-9A-22.

(a) The surcharge shall be collected on the same basis as premiums by each insurer, risk manager, or surplus lines producer.

(b) The surcharge is due and payable within 30 days after the premium for malpractice liability insurance has been received by the insurer, risk manager, or surplus lines producer from a health care provider in Georgia. If a surcharge is not paid as required by this Code section, the insurer, risk manager, or surplus lines producer responsible for the delinquency is liable for the surcharge plus a penalty equal to 10 percent of the amount of the surcharge.

(c) If the annual premium surcharge is not paid within the time limit specified in subsection (b) of this Code section, the certificate of authority of the insurer, risk manager, or surplus lines producer shall be suspended until the annual premium surcharge is paid.

9-9A-23.

(a) The Commissioner may adopt rules establishing the following:

(1) The manner of determination of the surcharge for a health care provider that establishes financial responsibility in a way other than by a policy of malpractice liability insurance; and

(2) The manner of payment of the surcharge by such health care provider.

(b) The surcharge calculation established under subsection (a) of this Code section must provide comparability in rates for insured and self-insured hospitals. This surcharge may not exceed the surcharge that would be charged by the residual authority if the health care provider electing to establish financial responsibility in this manner had applied to the residual authority for insurance.

ARTICLE 5

9-9A-30.

(a) The patient´s compensation fund is hereby created to be collected and received by the Commissioner for exclusive use for the purposes stated in this article.

(b) The fund and any income from the fund shall be held in trust, deposited in a segregated account, invested, and reinvested by the Commissioner as authorized by Title 33 and does not become a part of the state general fund.

(c) Proceeds of the annual surcharge levied on all health care providers in Georgia under Article 4 of this chapter shall be deposited in the fund.

9-9A-31.

(a) The Commissioner, using money from the patient´s compensation fund, as considered necessary, appropriate, or desirable, may purchase or retain the services of persons, firms, and corporations to aid in protecting the fund against claims. The Commissioner shall utilize the services of the Attorney General or retain the services of counsel described in subsection (b) of this Code section to represent the department when a trial court determination will be necessary to resolve a claim against the fund.

(b) When retaining legal services under subsection (a) of this Code section, the Commissioner shall retain competent and experienced legal counsel licensed to practice law in Georgia to assist in litigation or other matters pertaining to the fund.

(c) The Commissioner shall have the sole authority for the following:

(1) Making a decision regarding the settlement of a claim against the patient compensation fund; and

(2) Determining the reasonableness of any fee submitted to the department by an attorney who defends the patient compensation fund under this Code section.

(d) All expenses of collecting, protecting, and administering the fund shall be paid from the fund.

9-9A-132.

(a) Claims for payment from the patient´s compensation fund that become final during the first six months of the calendar year must be computed on June 30 and must be paid not later than the following July 15. Claims for payment from the fund that become final during the last six months of the calendar year must be computed on December 31 and must be paid not later than the following January 15.

(b) If the balance in the fund is insufficient to pay in full all claims that have become final during a six-month period, the amount paid to each claimant must be prorated. Any

amount left unpaid as a result of the proration must be paid before the payment of claims that become final during the following six-month period.

9-9A-33.

The state auditor shall issue a warrant in the amount of each claim submitted to the auditor against the patient´s compensation fund on June 30 and December 31 of each year. The only claim against the fund shall be a voucher or other appropriate request by the Commissioner after the Commissioner receives:

(1) A certified copy of a final judgment against a health care provider; or

(2) A certified copy of a court approved settlement against a health care provider.

9-9A-34.

(a) If an annual aggregate for a health care provider qualified under this chapter has been paid by or on behalf of the health care provider, all amounts that may subsequently become due and payable to a claimant arising out of an act of malpractice of the health care provider occurring during the year in which the annual aggregate was exhausted shall be paid from the patient´s compensation fund under the following terms and conditions:

(1) A health care provider whose annual aggregate has been exhausted has no right to object to or refuse permission to settle such a claim; and

(2) If a health care provider or the Commissioner and claimant agree on a settlement, the following procedure must be followed:

(A) A petition shall be filed by the claimant with the court in which the action is pending against the health care provider or, if none is pending, in the Superior Court of Fulton County, seeking approval of the agreed settlement;

(B) A copy of the petition shall be served on the Commissioner and the health care provider at least ten days before filing and must contain sufficient information to inform the other parties about the nature of the claim and the amount of the proposed settlement;

(C) The Commissioner may agree to the settlement, or the Commissioner may file written objections to the settlement. The agreement or objections shall be filed within 20 days after the petition is filed;

(D) The judge of the court in which the petition is filed shall set the petition for approval or, if objections have been filed, for hearing, as soon as practicable. The court shall give notice of the hearing to the claimant, the health care provider, and the Commissioner;

(E) At the hearing, the Commissioner, the claimant, and the health care provider may introduce relevant evidence to enable the court to determine whether or not the petition

should be approved if the evidence is submitted on agreement without objections. If the Commissioner and the claimant cannot agree on the amount, if any, to be paid out of the patient´s compensation fund, the court shall determine the amount for which the fund is liable and render a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patient´s compensation fund, the court shall consider the liability of the health care provider as admitted and established; and

(F) A settlement approved by the court may not be appealed. A judgment of the court fixing damages recoverable in a contested proceeding is appealable under the rules governing appeals in other civil cases tried by the court.

(b) The Commissioner may adopt rules implementing this Code section.

9-9A-35.

The following are exempt from Article 3 of Chapter 5 of Title 50, governing state purchasing:

(1) Technical contractual personnel and services retained by the Commissioner for protecting and administering the patient´s compensation fund; and

(2) Purchasing of annuities for structuring settlements from the patient´s compensation fund or in combination with the patient´s compensation fund and the health care provider´s insurer.

ARTICLE 6

9-9A-40.

The filing of a proposed complaint shall toll the applicable statute of limitations to and including a period of 90 days following the receipt of the opinion of the medical review panel by the claimant.

9-9A-41.

(a) Except as provided in subsection (b) of this Code section, an action against a health care provider may not be commenced in a court in Georgia before:

(1) The claimant´s proposed complaint has been presented to a medical review panel established under Article 7 of this chapter; and

(2) An opinion is given by that panel.

(b)(1) A claimant may commence an action in court for malpractice without the presentation of the claim to a medical review panel if the claimant and all parties named as defendants in the action agree that the claim is not to be presented to a medical review

panel. The agreement must be in writing and must be signed by each party or an authorized agent of the party. The claimant must attach a copy of the agreement to the complaint filed with the court in which the action is commenced.

(2) A claimant may commence an action against a health care provider for malpractice without submitting a proposed complaint to a medical review panel if the claimant´s pleadings include a declaration that the patient seeks damages from the health care provider in an amount not greater than $15,000.00. In an action commenced under this paragraph, the claimant is barred from recovering any amount greater than $15,000.00, unless the claimant subsequently learns, during the pendency of the action, that the bodily injury is more serious than previously believed and that $15,000.00 is insufficient compensation for the bodily injury. In such a case, the claimant may move that the action be dismissed without prejudice and, upon dismissal of the action, may file a proposed complaint based upon the same allegations of malpractice as were asserted in the action dismissed under this paragraph. In a second action commenced in court following the medical review panel´s proceeding on the proposed complaint, the patient may recover an amount greater than $15,000.00.

9-9A-42.

Within ten days after receiving a proposed complaint under Code Section 9-11-8, the Commissioner shall forward a copy of the complaint by registered or certified mail to each health care provider named as a defendant at the defendant´s last and usual place of residence or the defendant´s office.

9-9A-43.

A medical liability insurer of a health care provider against whom an action has been filed under Code Section 9-11-8 shall provide written notice of the action to the Commissioner within 30 days after:

(1) The filing of the action; and

(2) The final disposition of the action.

9-9A-44.

(a) A health care provider´s insurer shall notify the Commissioner of any malpractice case upon which the insurer has placed a reserve of at least $125,000.00. The insurer shall give notice to the Commissioner under this subsection immediately after placing the reserve. The notice and all communications and correspondence relating to the notice are confidential and shall not be subject to Article 4 of Chapter 18 of Title 50, relating to inspection of public records.

(b) All malpractice claims settled or adjudicated to final judgment against a health care provider shall be reported to the Commissioner by the plaintiff˝s attorney and by the health care provider or the health care provider´s insurer or risk manager within 60 days following final disposition of the claim. The report to the Commissioner must state the following:

(1) The nature of the claim;

(2) The damages asserted and the alleged injury;

(3) The attorney´s fees and expenses incurred in connection with the claim or defense; and

(4) The amount of the settlement or judgment.

9-9A-45.

(a) At the time that it renders its opinion under Code Section 9-9A-71, the medical review panel as described in Article 7 of this chapter shall make a separate determination as to whether the name of the defendant health care provider should be forwarded to the appropriate board of professional registration for review of the health care provider´s fitness to practice the health care provider´s profession. The Commissioner shall forward the name of the defendant health care provider if the medical review panel unanimously determines that it should be forwarded. The medical review panel determination concerning the forwarding of the name of the defendant health care provider is not admissible as evidence in a civil action. In each case involving review of a health care provider´s fitness to practice forwarded under this Code section, the appropriate board of professional registration and examination may, in appropriate cases, take the following disciplinary action:

(1) Censure;

(2) Imposition of probation for a determinate period;

(3) Suspension of the health care provider´s license for a determinate period; or

(4) Revocation of the license.

(b) The appropriate board of professional registration and examination shall report to the Commissioner the board´s findings, the action taken, and the final disposition of each case involving review of a health care provider´s fitness to practice forwarded under this Code section.

ARTICLE 7

9-9A-50.

This article provides for the establishment of medical review panels to review proposed malpractice complaints against health care providers covered by this chapter.

9-9A-51.

Not earlier than 20 days after the filing of a proposed complaint, either party may request the formation of a medical review panel by serving a request by registered or certified mail upon all parties and the Commissioner.

9-9A-52.

(a) A medical review panel shall consist of one attorney and three health care providers.

(b) The attorney member of the medical review panel shall act as chairperson of the panel and in an advisory capacity but may not vote.

(c) The chairperson of the medical review panel shall expedite the selection of the other panel members, convene the panel, and expedite the panel´s review of the proposed complaint. The chairperson may establish a reasonable schedule for submission of evidence to the medical review panel but must allow sufficient time for the parties to make full and adequate presentation of related facts and authorities.

9-9A-53.

(a) Within 15 days after the filing of a request for formation of a medical review panel under Code Section 9-9A-51, the parties shall select a panel chairperson by agreement.

(b) If no agreement on a panel chairperson can be reached, and after the payment of a $25.00 fee, either party may request the clerk of the Supreme Court to draw at random a list of five names of attorneys who are qualified to practice law in this state; are presently on the rolls of the Supreme Court; and maintain offices in the county of venue designated in the proposed complaint or in a contiguous county. The chairperson shall be selected in the following manner:

(1) The clerk shall notify the parties, and the parties shall then strike names alternately with the plaintiff striking first until one name remains. The remaining attorney shall be the chairperson of the panel. After the striking, the plaintiff shall notify the chairperson and all other parties of the name of the chairperson; or

(2)(A) If a party does not strike a name within five days after receiving notice from the clerk, the opposing party shall, in writing, request the clerk to strike for the party; and the clerk shall strike for that party; and

(B) When one name remains, the clerk shall within five days notify the chairperson and all other parties of the name of the chairperson.

(c) Within 15 days after being notified by the clerk of being selected as chairperson, the chairperson shall:

(1) Send a written acknowledgment of appointment to the clerk; or

(2) Show good cause for relief from serving as provided in Code Section 9-9A-61.

9-9A-54.

Except for health care providers who are long-term care facility administrators, all health care providers in Georgia, whether in the teaching profession or otherwise, who hold a license to practice in their profession shall be available for selection as members of a medical review panel. Long-term care facility administrators may not be members of a medical review panel.

9-9A-55.

Each party to the action has the right to select one health care provider, and upon selection, the two health care providers thus selected shall select the third panel member of the medical review panel.

9-9A-56.

If there are multiple plaintiffs or defendants, only one health care provider shall be selected per side. The plaintiff, whether single or multiple, has the right to select one health care provider and the defendant, whether single or multiple, has the right to select one health care provider.

9-9A-57.

If there is only one party defendant who is an individual, two of the panel members selected must be members of the profession or specialty class of which the defendant is a member. If the individual defendant is a health care professional who specializes in a limited area, two of the panel members selected must be health care professionals who specialize in the same area as the defendant.

9-9A-58.

Within 15 days after the chairperson of a medical review panel is selected, both parties shall select a health care provider and the parties shall notify the other party and the chairperson of their selections. If a party fails to make a selection within 15 days, the chairperson shall make the selection and notify both parties. Within 15 days after their

selection, the health care provider members shall select the third member and notify the chairperson and the parties. If the providers fail to make a selection, the chairperson shall make the selection and notify both parties.

9-9A-59.

Within ten days after the selection of a medical review panel member, written challenge without cause may be made to the panel member. Upon challenge or excuse, the party whose appointee was challenged or dismissed shall select another panel member. If the challenged or dismissed panel member was selected by the other two panel members, the panel members shall make a new selection. If two such challenges are made and submitted, the chairperson shall within ten days appoint a panel consisting of three qualified panel members and each side shall, within ten days after the appointment, strike one panel member. The party whose appointment was challenged shall strike last, and the remaining member shall serve.

9-9A-60.

When a medical review panel is formed, the chairperson shall within five days notify the Commissioner and the parties by registered or certified mail of the following:

(1) The names and addresses of the panel members; and

(2) The date on which the last member was selected.

9-9A-61.

(a) A member of a medical review panel who is selected under this article shall serve unless:

(1) The parties by agreement excuse the panel member; or

(2) The panelist is excused as provided in this Code section for good cause shown.

(b) To show good cause for relief from serving, the attorney selected as chairperson of a medical review panel must serve an affidavit upon the clerk of the Supreme Court. The affidavit must set out the facts showing that service would constitute an unreasonable burden or undue hardship. The clerk may excuse the attorney from serving. The attorney shall notify all parties, who shall then select a new chairperson as provided in Code Section 9-9A-53.

(c) To show good cause for relief from serving, a health care provider member of a medical review panel must serve an affidavit upon the panel chairperson. The affidavit must set out the facts showing that service would constitute an unreasonable burden or undue hardship. The chairperson may excuse the member from serving and notify all

parties. A new panel member shall be selected as provided in Code Sections 9-9A-55 and 9-9A-58.

9-9A-62.

(a) The medical review panel shall give its expert opinion within 180 days after the selection of the last member of the initial panel. However, the panel has 90 days after the selection of a new member to give an expert opinion if:

(1) The chairperson of the panel is removed under Code Section 9-9A-64, another member of the panel is removed under Code Section 9-9A-65, or any member of the panel, including the chairperson, is removed by a court order; and

(2) A new member is selected to replace the removed member more than 90 days after the last member of the initial panel is selected.

(b) If the panel has not given an opinion within the time allowed under subsection (a) of this Code section, the panel shall submit a report to the Commissioner, stating the reasons for the delay.

9-9A-63.

A party, attorney, or panel member who fails to act as required by this article without good cause shown is subject to mandate or appropriate sanctions upon application to the court designated in the proposed complaint as having jurisdiction.

9-9A-64.

(a) The Commissioner may remove the chairperson of the panel if the Commissioner determines that the chairperson is not fulfilling the duties imposed upon the chairperson by this article.

(b) If the chairperson is removed under this Code section, a new chairperson shall be selected as provided in Code Section 9-9A-53.

9-9A-65.

(a) The chairperson may remove a member of the panel if the chairperson determines that the member is not fulfilling the duties imposed upon the panel members by this article.

(b) If a member is removed under this Code section, a new member shall be selected as provided in Code Sections 9-9A-55 and 9-9A-58.

9-9A-66.

(a) The evidence in written form to be considered by the medical review panel shall be promptly submitted by the respective parties.

(b) The evidence may consist of medical charts, X-rays, lab tests, excerpts of treatises, depositions of witnesses including parties, and any other form of evidence allowable by the medical review panel.

(c) Depositions of parties and witnesses may be taken before the convening of the panel.

(d) The chairperson shall ensure that before the panel gives its expert opinion under Code Section 9-9A-71, each panel member has the opportunity to review every item of evidence submitted by the parties.

(e) Before considering any evidence or deliberating with other panel members, each member of the medical review panel shall take an oath in writing on a form provided by the panel chairperson, which must read as follows:

'I (swear) (affirm) under penalties of perjury that I will well and truly consider the evidence submitted by the parties; that I will render my opinion without bias, based upon the evidence submitted by the parties; and that I have not and will not communicate with any party or representative of a party before rendering my opinion, except as authorized by law.'

9-9A-67.

Neither a party, a party´s agent, a party´s attorney, nor a party´s insurance carrier may communicate with any member of the panel, except as authorized by law, before the giving of the panel´s expert opinion under Code Section 9-9A-71.

9-9A-68.

The chairperson of the panel shall advise the panel relative to any legal question involved in the review proceeding and shall prepare the opinion of the panel as provided in Code Section 9-9A-71.

9-9A-69.

(a) Either party, after submission of all evidence and upon ten days´ notice to the other side, has the right to convene the panel at a time and place agreeable to the members of the panel. Either party may question the panel concerning any matters relevant to issues to be decided by the panel before the issuance of the panel´s report.

(b) The chairperson of the panel shall preside at all meetings. Meetings shall be informal.

9-9A-70.

(a) The panel has the right and duty to request all necessary information.

(b) The panel may consult with medical authorities.

(c) The panel may examine reports of other health care providers necessary to fully inform the panel regarding the issue to be decided.

(d) Both parties shall have full access to any material submitted to the panel.

9-9A-71.

(a) The panel has the sole duty to express the panel´s expert opinion as to whether or not the evidence supports the conclusion that the defendant or defendants acted or failed to act within the appropriate standards of care as charged in the complaint.

(b) After reviewing all evidence and after any examination of the panel by counsel representing either party, the panel shall, within 30 days, give one or more of the following expert opinions, which must be in writing and signed by the panel members:

(1) The evidence supports the conclusion that the defendant or defendants failed to comply with the appropriate standard of care as charged in the complaint;

(2) The evidence does not support the conclusion that the defendant or defendants failed to meet the applicable standard of care as charged in the complaint;

(3) There is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury; or

(4) The conduct complained of was or was not a factor of the resultant damages. If so, whether the plaintiff suffered:

(A) Any disability and the extent and duration of the disability; and

(B) Any permanent impairment and the percentage of the impairment.

9-9A-72.

A report of the expert opinion reached by the medical review panel is admissible as evidence in any action subsequently brought by the claimant in a court of law. However, the expert opinion is not conclusive, and either party, at the party´s cost, has the right to call any member of the medical review panel as a witness. If called, that panel member shall appear and testify.

9-9A-73.

A panel member has absolute immunity from civil liability for all communications, findings, opinions, and conclusions made in the course and scope of duties prescribed by this chapter.

9-9A-74.

(a) Each health care provider member of the medical review panel is entitled to be paid:

(1) Up to $350.00 for all work performed as a member of the panel, exclusive of time involved if called as a witness to testify in court; and

(2) Reasonable travel expenses.

(b) The chairperson of the panel is entitled to be paid:

(1) At the rate of $250.00 per diem, not to exceed $2,000.00; and

(2) Reasonable travel expenses.

(c) The chairperson shall keep an accurate record of the time and expenses of all the members of the panel. The record shall be submitted to the parties for payment with the panel´s report.

(d) Fees of the panel, including travel expenses and other expenses of the review, shall be paid by the side in whose favor the majority opinion is written. If there is no majority opinion, each side shall pay 50 percent of the cost.

9-9A-75.

The chairperson of the medical review panel shall submit by registered or certified mail within 5 days after the panel gives its opinion a copy of the panel´s report to the Commissioner and all parties and attorneys.

ARTICLE 8

9-9A-80.

(a) A court having jurisdiction over the subject matter and the parties to a proposed complaint filed with the Commissioner under this article may, upon the filing of a copy of the proposed complaint and a written motion under this article, do one or both of the following:

(1) Preliminarily determine an affirmative defense or issue of law or fact that may be preliminarily determined under Chapter 11 of Title 9, the 'Georgia Civil Practice Act'; or

(2) Compel discovery in accordance with Chapter 11 of Title 9, the 'Georgia Civil Practice Act.'

(b) The court has no jurisdiction to rule preliminarily upon any affirmative defense or issue of law or fact reserved for written opinion by the medical review panel under Code Section 9-9A-71.

(c) The court has jurisdiction to entertain a motion filed under this article only during that time after a proposed complaint is filed with the Commissioner under this article but before the medical review panel gives the panel´s written opinion under Code Section 9-9A-71.

(d) The failure of any party to move for a preliminary determination or to compel discovery under this article before the medical review panel gives the panel´s written opinion under Code Section 9-9A-71 does not constitute the waiver of any affirmative defense or issue of law or fact.

9-9A-81.

(a) A party to a proceeding commenced under this chapter, the Commissioner, or the chairperson of a medical review panel, if any, may invoke the jurisdiction of the court by paying the statutory filing fee to the clerk and filing a copy of the proposed complaint and motion with the clerk.

(b) The filing of a copy of the proposed complaint and motion with the clerk confers jurisdiction upon the court over the subject matter and the parties to the proceeding for the limited purposes stated in this article, including the taxation and assessment of costs or the allowance of expenses, including reasonable attorney´s fees, or both.

(c) The moving party or the moving party´s attorney shall cause as many summonses as are necessary to be issued by the clerk and served on the Commissioner, each nonmoving party to the proceedings, and the chairperson of the medical review panel, if any, unless the Commissioner or the chairperson is the moving party, together with a copy of the proposed complaint and a copy of the motion.

9-9A-82.

(a) Each nonmoving party to the proceeding, including the Commissioner and the chairperson of the medical review panel, if any, shall have a period of 20 days after service, or a period of 23 days after service if service is by mail, to appear and file and serve a written response to the motion, unless the court, for cause shown, orders the period extended.

(b) The court shall enter a ruling on the motion:

(1) Within 30 days after the motion is heard; or

(2) If no hearing is requested, granted, or ordered, within 30 days after the date on which the last written response to the motion is filed.

(c) The court shall order the clerk to serve a copy of the court´s ruling on the motion by first-class mail on the Commissioner, each party to the proceeding, and the chairperson of the medical review panel, if any.

9-9A-83.

Upon the filing of a copy of the proposed complaint and motion with the clerk of the court, all further proceedings before the medical review panel shall be stayed automatically until the court has entered a ruling on the motion.

9-9A-84.

The court may enforce its ruling on any motion filed under this chapter in accordance with Chapter 11 of Title 9, the 'Georgia Civil Practice Act,' subject to the right of appeal.

ARTICLE 9

9-9A-90.

Liability may not be imposed on a health care provider on the basis of an alleged breach of contract, express or implied, assuring results to be obtained from any procedure undertaken in the course of health care unless the contract is in writing and signed by that health care provider or by an authorized agent of the health care provider.

9-9A-91.

A rebuttable presumption is created that the consent is an informed consent if a patient´s written consent is:

(1) Signed by the patient or the patient´s authorized representative;

(2) Witnessed by an individual at least 18 years of age; and

(3) Explained, orally or in the written consent, to the patient or the patient´s authorized representative before a treatment, procedure, examination, or test is undertaken.

9-9A-92.

The explanation given in accordance with Code Section 9-9A-91 must include the following information:

(1) The general nature of the patient´s condition;

(2) The proposed treatment, procedure, examination, or test;

(3) The expected outcome of the treatment, procedure, examination, or test;

(4) The material risks of the treatment, procedure, examination, or test; and

(5) The reasonable alternatives to the treatment, procedure, examination, or test.

9-9A-93.

(a) This article does not relieve a qualified health care provider of the duty to obtain an informed consent.

(b) This article does not prevent a patient, after having signed a consent, from withdrawing that consent.

(c) This article does not require that a patient´s consent or the information described under Code Section 9-9A-91 be in writing in all cases.

(d) Compliance with this article is not required to create an informed consent.

(e) A patient may refuse to receive some or all of the information described in Code Section 9-9A-91.

(f) Code Sections 9-9A-90 and 9-9A-91 do not apply to a person who is mentally incapable of understanding the information required to be provided by Code Section 9-9A-91. This Code section does not require consent to health care in an emergency.

ARTICLE 10

9-9A-100.

Only while malpractice liability insurance remains in force are the health care provider and the health care provider´s insurer liable to a patient or the patient´s representative for malpractice to the extent and in the manner specified in this chapter.

9-9A-101.

The filing of proof of financial responsibility with the Commissioner constitutes, on the part of the insurer, a conclusive and unqualified acceptance of this chapter.

9-9A-102.

A provision in a policy attempting to limit or modify the liability of the insurer contrary to this chapter is void.

9-9A-103.

Every policy issued under this chapter is considered to include the following provisions and any change made by general law as fully as if the change were written in the policy:

(1) The insurer assumes all obligations to pay an award imposed against its insured under this chapter;

(2) A termination of any policy by cancellation initiated by the insurance company is not effective for patients claiming against the insured covered by the policy, unless at least 30 days before the taking effect of the cancellation, a written notice giving the date upon

which termination becomes effective has been received by the insured and the Commissioner at their respective offices; and

(3) A termination of any policy by cancellation initiated by the insured is not effective for patients claiming against the insured covered by the policy, unless at least 30 days before the taking effect of the cancellation, a written notice giving the date upon which termination becomes effective has been received by the Commissioner.

9-9A-104.

If an insurer fails or refuses to pay a final judgment, except during the pendency of an appeal, or fails or refuses to comply with this chapter, in addition to any other legal remedy, the Commissioner may also revoke the approval of the insurer´s policy form until the insurer pays the award or judgment or has complied with the violated provisions of this chapter and has resubmitted its policy form and received the approval of the Commissioner.

ARTICLE 11

9-9A-110.

As used in this article, 'cost of the periodic payments agreement' means the amount expended by the health care provider or its insurer, the Commissioner, or the Commissioner and the health care provider or its insurer, at the time the periodic payments agreement is made, to obtain the commitment from a third party to make available money for use as future payment, the total of which may exceed the limits provided in Code Section 9-9A-112.

9-9A-111.

As used in this article, 'periodic payments agreement' means a contract between a health care provider or its insurer and the patient or the patient´s estate under which the health care provider is relieved from possible liability in consideration of:

(1) A present payment of money to the patient or the patient´s estate; and

(2) One or more payments to the patient or the patient´s estate in the future; whether or not some or all of the payments are contingent upon the patient´s survival to the proposed date of payment.

9-9A-112.

(a) The total amount recoverable for an injury or death of a patient may not exceed $750,000.00 for an act of malpractice that occurs after June 30, 2005.

(b) A health care provider qualified under this chapter is not liable for an amount in excess of $250,000.00 for an occurrence of malpractice.

(c) Any amount due from a judgment or settlement that is in excess of the total liability of all liable health care providers, subject to subsections (a), (b), and (d) of this Code section, shall be paid from the patient´s compensation fund under Code Section 9-9A-120.

(d) If a health care provider qualified under this chapter admits liability or is adjudicated liable solely by reason of the conduct of another health care provider who is an officer, agent, or employee of the health care provider acting in the course and scope of employment and qualified under this chapter, the total amount that shall be paid to the claimant on behalf of the officer, agent, or employee and the health care provider by the health care provider or its insurer is $250,000.00. The balance of an adjudicated amount to which the claimant is entitled shall be paid by other liable health care providers or the patient´s compensation fund, or both.

9-9A-113.

(a) If the possible liability of the health care provider to the patient is discharged solely through an immediate payment, the limitations on recovery from a health care provider stated in subsections (b) and (d) of Code Section 9-9A-112 shall apply without adjustment.

(b) If the health care provider agrees to discharge its possible liability to the patient through a periodic payments agreement, the amount of the patient´s recovery from a health care provider in a case under this subsection is the amount of any immediate payment made by the health care provider or the health care provider´s insurer to the patient, plus the cost of the periodic payments agreement to the health care provider or the health care provider´s insurer. For the purpose of determining the limitations on recovery stated in subsections (b) and (d) of Code Section 9-9A-112 and for the purpose of determining the question under Code Section 9-9A-122 of whether the health care provider or the health care provider´s insurer has agreed to settle its liability by payment of its policy limits, the sum of the following must exceed $187,000.00:

(1) The present payment of money to the patient or the patient´s estate by the health care provider or the health care provider´s insurer; and

(2) The cost of the periodic payments agreement expended by the health care provider or the health care provider´s insurer.

(c) More than one health care provider may contribute to the cost of a periodic payments agreement, and in such an instance the sum of the amounts expended by each health care provider for immediate payments and for the cost of the periodic payments agreement shall be used to determine whether the $187,000.00 requirement in subsection (b) of this Code

section has been satisfied. However, one health care provider or its insurer must be liable for at least $50,000.00.

9-9A-114.

(a) If the possible liability of the patient´s compensation fund to the patient is discharged solely through a direct payment made under Code Section 9-9A-120, the limitations on recovery from the patient´s compensation fund established under Code Section 9-9A-112 apply without adjustment.

(b) If an agreement is made to discharge the fund´s possible liability to the patient through a periodic payments agreement, and for the purposes of the limitations on recovery from the fund established under Code Section 9-9A-112, the amount of the patient´s recovery from the fund is:

(1) The amount of any immediate payment made directly to the patient from the fund; and

(2) The cost of the periodic payments agreement paid by the Commissioner on behalf of the fund.

ARTICLE 12

9-9A-120.

(a) The obligation to pay an amount from the patient´s compensation fund under Code Sections 9-9A-34, 9-9A-112, or 9-9A-122 may be discharged as follows:

(1) Payment in one lump amount;

(2) An agreement requiring periodic payments from the fund over a period of years;

(3) The purchase of an annuity payable to the patient; or

(4) Any combination of paragraphs (1), (2), and (3) of this subsection.

(b) The Commissioner may contract with approved insurers to insure the ability of the fund to make periodic payments under paragraph (2) of subsection (a) of this Code section.

9-9A-121.

Notwithstanding Article 5 of this chapter, the Commissioner may:

(1) Discharge the possible liability of the patient´s compensation fund to a patient through a periodic payments agreement as defined in Code Section 9-9A-111; and

(2) Combine money from the fund with money of the health care provider or its insurer to pay the cost of the periodic payments agreement with the patient or the patient´s estate. However, the amount provided by the Commissioner may not exceed 80 percent of the total amount expended for the agreement.

9-9A-122.

If a health care provider or its insurer has agreed to settle its liability on a claim by payment of its policy limits of $250,000.00, and the claimant is demanding an amount in excess of that amount, the following procedure must be followed:

(1) A petition shall be filed by the claimant in the court named in the proposed complaint, or in the Superior Court of Fulton County, at the claimant´s election, seeking:

(A) Approval of an agreed settlement, if any; or

(B) Demanding payment of damages from the patient´s compensation fund.

(2) A copy of the petition with summons shall be served on the Commissioner, the health care provider, and the health care provider´s insurer and must contain sufficient information to inform the other parties about the nature of the claim and the additional amount demanded.

(3) The Commissioner and either the health care provider or the insurer of the health care provider may agree to a settlement with the claimant from the patient´s compensation fund, or the Commissioner, the health care provider, or the insurer of the health care provider may file written objections to the payment of the amount demanded. The agreement or objections to the payment demanded shall be filed within 20 days after service of summons with copy of the petition attached to the summons.

(4) The judge of the court in which the petition is filed shall set the petition for approval or, if objections have been filed, for hearing, as soon as practicable. The court shall give notice of the hearing to the claimant, the health care provider, the insurer of the health care provider, and the Commissioner.

(5) At the hearing, the Commissioner, the claimant, the health care provider, and the insurer of the health care provider may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if the evidence is submitted on agreement without objections. If the Commissioner, the health care provider, the insurer of the health care provider, and the claimant cannot agree on the amount, if any, to be paid out of the patient´s compensation fund, the court shall, after hearing any relevant evidence on the issue of claimant´s damage submitted by any of the parties described in this Code section, determine the amount of claimant´s damages, if any, in excess of the $250,000.00 already paid by the insurer of the health care provider. The court shall determine the amount for which the fund is liable and make a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patient´s compensation fund, the court shall consider the liability of the health care provider as admitted and established.

(6) A settlement approved by the court may not be appealed. A judgment of the court fixing damages recoverable in a contested proceeding is appealable pursuant to the rules governing appeals in any other civil case tried by the court.

(7) A release executed between the parties does not bar access to the patient´s compensation fund unless the release specifically provides otherwise.

9-9A-123.

If a health care provider or the health care provider´s surety or liability insurance carrier fails to pay any agreed settlement or final judgment within 90 days, the agreed settlement or final judgment shall be paid from the patient´s compensation fund, and the fund shall be subrogated to any and all of claimant´s rights against the health care provider, the health care provider´s surety or liability insurance carrier, or both, with interest, reasonable costs, and attorney´s fees.

ARTICLE 13

9-9A-130.

Except as provided in Code Section 9-9A-122, any advance payment made by the defendant health care provider or the health care provider´s insurer to or for the plaintiff or any other person may not be construed as an admission of liability for injuries or damages suffered by the plaintiff or anyone else in an action brought for medical malpractice.

9-9A-131.

(a) Evidence of an advance payment is not admissible until there is a final judgment in favor of the plaintiff. In this case the court shall reduce the judgment to the plaintiff to the extent of the advance payment. The advance payment inures to the exclusive benefit of the defendant or the defendant´s insurer making the payment.

(b) If the advance payment exceeds the liability of the defendant or the insurer making the advance payment, the court shall order any adjustment necessary to equalize the amount that each defendant is obligated to pay, exclusive of costs. An advance payment in excess of an award is not repayable by the person receiving the advance payment.

9-9A-132.

A patient´s claim for compensation under this chapter is not assignable.

ARTICLE 14

9-9A-140.

The purpose of this article is to make malpractice liability insurance available to risks as defined in Code Section 9-9A-2.

9-9A-141.

(a) The residual malpractice insurance authority is hereby created.

(b) The Insurance Department is designated as the residual malpractice insurance authority for the purposes of this article.

(c) The authority is authorized to issue medical malpractice liability insurance in accordance with Title 33.

9-9A-142.

The Commissioner shall appoint a risk manager for the authority. The separate, personal, or independent assets of the risk manager are not liable for or subject to use or expenditure for the purpose of providing insurance by the authority.

9-9A-143.

In the administration and provision for malpractice liability insurance by the authority, the risk manager shall do the following:

(1) Obey all Georgia statutes and rules that apply to insurance pursuant to Title 33;

(2) Prepare and file appropriate forms with the department;

(3) Prepare and file premium rates with the department;

(4) Perform the underwriting function;

(5) Dispose of all claims and litigations arising out of insurance policies;

(6) Maintain adequate books and records;

(7) File an annual financial statement regarding the authority´s operations under this chapter with the department on forms prescribed by the Commissioner;

(8) Obtain private reinsurance for the authority, if necessary;

(9) Prepare and file for approval of the Commissioner a schedule of agent´s compensation; and

(10) Prepare and file a plan of operations with the Commissioner for approval.

9-9A-144.

The risk manager shall receive, as compensation for services, a percentage of all premiums received by the risk manager under this chapter, as determined by the Commissioner. The rate of compensation may be adjusted by the Commissioner.

9-9A-145.

If a risk, after diligent effort, has been declined by at least two insurers, the risk may forward an application to the risk manager, together with evidence of the two declinations.

9-9A-146.

If the risk manager declines to accept the risk, notice of declination, together with the reasons, shall be sent to the applicant and the Commissioner. The applicant has ten days after the date of notice to file an appeal for review by the Commissioner. On appeal, the Commissioner shall review the decision of the risk manager and enter an appropriate order.

9-9A-147.

All money appropriated by the state and any surplus of premiums over losses and expenses received by the authority shall be placed in a segregated fund and shall be invested and reinvested by the Commissioner within any limitations set forth in Title 33. Investment income generated shall remain in the segregated fund.

ARTICLE 15

9-9A-150.

When a plaintiff is represented by an attorney in the prosecution of the plaintiff´s claim, the plaintiff´s attorney´s fees from any award made from the patient´s compensation fund may not exceed 15 percent of any recovery from the fund.

9-9A-151.

A patient has the right to elect to pay for the attorney´s services on a mutually satisfactory per diem basis. The election, however, must be exercised in written form at the time of employment.″

SECTION 2.

This Act shall become effective July 1, 2005, only if Senate Bill 3 (LC 14 8923), in substantially the same form as introduced, or a similar bill is enacted by the General Assembly in the 2005 regular session and signed by the Governor with respect to limitations on noneconomic damages of $250,000.00 against one or more health care providers or a single medical facility in certain actions relating to health care.

SECTION 3.

All laws and parts of laws in conflict with this Act are repealed.